Members

Rep. Timothy Brown, Chairperson
Rep. Mary Kay Budak
Rep. Suzanne Crouch
Rep. Charlie Brown
Rep. William Crawford
Rep. Peggy Welch
Sen. Patricia Miller
Sen. Robert Meeks
Sen. Gary Dillon
Sen. Connie Sipes
Sen. Billie Breaux
Sen. Vi Simpson

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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Authority: ***IC 2-5-26***

MEETING MINUTES[1]

Meeting Date:	**August 10, 2006**
Meeting Time:	**1:30 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Rep. Timothy Brown, Chairperson; Rep. Mary Kay Budak; Rep. Suzanne Crouch; Rep. Charlie Brown; Rep. William Crawford; Rep. Peggy Welch; Sen. Patricia Miller; Sen. Robert Meeks; Sen. Gary Dillon; Sen. Connie Sipes; Sen. Billie Breaux; Sen. Vi Simpson.**

Members Absent: **None.**

Rep. Tim Brown, Chair, called the first meeting of the Select Joint Commission on Medicaid Oversight to order at approximately 1:35 p.m.

Rep. David Orentlicher Presentation

After the introduction of Commission members, Rep. Brown called upon Rep. David Orentlicher for a presentation entitled "Expanding the Pool: A Proposal to Increase Health Insurance Coverage in Indiana". (See Exhibit 1 for a copy of Rep. Orentlicher's slide presentation.) Rep. Orentlicher explained how he had examined coverage expansion models from other states and the federal government and briefly described the plans (TennCare, Oregon, and Veterans Health Administration).

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[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Rep. Orentlicher described TennCare as being designed and implemented very quickly with all Medicaid recipients plus persons up to 200% of the federal poverty level (FPL) to be enrolled in a managed care plan. The plan had a comprehensive set of benefits, including prescription drugs, with no caps on benefits, and with co-payments only for the expansion population. While access to care initially improved (8.9% of the Tennessee population was uninsured in 1993, improving to 5.9% in 1997), Rep. Orentlicher stated that the uninsured rate increased to 9.8% again by 2005.

Rep. Orentlicher also described the Oregon Health Plan, which was initially Medicaid reform legislation but was expanded to provide access to care for persons with incomes up to 100% of FPL with some restriction in benefits. The plan involved rationing according to a priority list developed by the Oregon Health Services Commission. Once the legislature determined the total budget, the set of covered and uncovered services was determined by an independent actuary. Enrollment increased by 39%, while costs increased by 36%. While initially improving coverage, Rep. Orentlicher stated that in 2005, Oregon's uninsured rate was back to where it was before the plan was implemented.

Rep. Orentlicher described the Veterans Health Administration (VHA) as a model for reengineering health care delivery. He described the plan budget as being flat between 1995 and 2000, while the number of patients increased by 40%. He said this was possible by:

- Defining practice standards that have been shown to result in better patient outcomes.
- Monitoring performance and measuring outcomes.
- Rewarding good performance and managing underperformance.
- Optimizing the use of technology.
- Promoting patient safety initiatives to reduce medical errors.

Rep. Orentlicher added that the plan has resulted in:

- A shift from hospital-based care to out-patient care.
- A decrease in staffing of 11%.
- A significant elimination of VHA forms.
- Savings in the pharmacy benefits management program.

Rep. Orentlicher also described HB 1352 (2006) which he introduced in the 2006 legislative session. HB 1352 would establish a pilot program for Medicaid recipients in Marion County to receive Medicaid services at Wishard Hospital. He described the pilot program as being a program of health care modeled after the VA's quality improvement initiative and which would include payment incentives for health care providers, among other provisions.

Rep. Orentlicher described his proposal for 2007 as including the pilot program from HB 1352 (2006) along with a pilot program providing for a buy-in for small businesses.

Mr. Lee Livin, Chief Financial Officer, Wishard Hospital

Rep. Orentlicher introduced Mr. Lee Livin, CFO, Wishard Hospital. Mr. Livin stated that Rep. Orentlicher had requested that the Health and Hospital Corporation, Wishard Health Services, and the IU Medical Group investigate potential options to insure workers in small businesses, which will help the working poor. He stated that they have found that a large percentage of the uninsured individuals who access their health system are employed. Mr. Livin related some of the information reported in a study in Tennessee and funded by the federal Health Resources and Services Administration in the U.S. Department of Health and Human Services.

Mr. Livin stated that at Wishard only 10% of their patients are commercially insured and approximately 36% are uninsured by any source. He further described the Wishard Advantage

Program, a program developed in 1997 as a health cost assistance program and not an insurance plan. The enrollment in the program is approaching 60,000 individuals, up from 40,000 at the beginning of 2005. More than 70% of the families have an employed family member with an average hourly wage between $6 and $7. During 2005, Wishard provided approximately $140 million of uncompensated care to Wishard Advantage enrollees and more than $200 million when self-paying clients were included.

Mr. Livin suggested that a small-employer health insurance plan must provide comprehensive coverage and be affordable to be marketable. Consequently, the plan administrator, insurer, and healthcare providers must be willing to accept less than usual reimbursement. He added that managed care contracts which include a "most favored nation" clause would be problematic because of the reimbursement discount which must be offered. ("Most favored nation" clauses are requirements imposed by insurance contracts on providers requiring providers to offer to the insurance company the lowest price offered to others.)

Mr. Livin suggested that a viable insurance product can be marketed to small businesses at a minimum average monthly premium of $150 to $175 per individual and that Tennessee has recently begun a program where the state, the employer, and the employee equally share in the cost of the premium.

(See Exhibit 2 for a written copy of Mr. Livin's testimony.)

Rep. Crawford wondered as to whether there might be an incentive for employers to dump insured workers with such a program.

Mr. Livin, responding to a question as to what the $200 million in uncompensated care at Wishard was based on, stated that the number was based on total charges and not discounted or reduced charges.

Rep. Welch stated that the federal government is looking into requiring states to get more involved in the provision of insurance for uninsured individuals.

Rep. Tim Brown stated that VA health care and Medicaid were not exactly comparable due to the differing populations that were involved. Rep. Brown also commented that Rep. Orentlicher provided a good historical perspective on approaches that have been attempted and that anything that involves quality improvement should be examined.

FSSA Update - Mitch Roob, Secretary of the Office of Family and Social Services

Mr. Mitch Roob, Secretary, FSSA, provided an update of the Family and Social Services Administration in state FY 2007. (See Exhibit 3 for a copy of Mr. Roob's slide presentation.) Mr. Roob explained that FSSA's primary goals for FY 2006 of controlling the Medicaid growth rate and implementing a financial accounting system and policy review process were accomplished.

Mr. Roob stated that in FY 2006 FSSA reduced a 10% growth rate to 5% as instructed by the legislature, while serving 22,000 more Hoosiers than in the previous year. FSSA also reduced the backlog of 13,500 cases awaiting medical eligibility review, reduced the number of people on Medicaid waiver waiting lists, and provided child care vouchers to 3,000 more children.

Mr. Roob also stated that for the first time, FSSA implemented an agencywide accounting system. The new accounting system allows consistent tracking of all expenditures, enhances the agency's ability to monitor funds, and provides for automated reporting ability and internal monthly financial

reviews and public quarterly financial reviews.

Mr. Roob stated that the FY 2007 budget maintains a 5% growth rate in Medicaid spending, which should fund anticipated increased enrollment, implementation of new managed care contracts, increased managed care payments of 8.4%, and does not incorporate savings due to care management of the aged, blind, and disabled population. Mr. Roob also stated that the budget includes expected increases in Medicare Part D payments, includes funding for the mental health cap expansion, and provides care for nearly 25,000 more people than served in FY 2006. The aged, blind, and disabled categories are estimated to have an expenditure increase of 2.5% for inpatient hospital services, 6.5% for outpatient hospital services, 8.5% for physician services, 5.0% for dental services, 9.0% for home health, and 7% to 9% for pharmacy services. Mr. Roob added that there will be three new statewide managed care providers on January 1, 2007, and that mental health care is now under managed care, but dental care is not.

Objectives for FY 2007 for the Division of Aging include an increase of waiver eligibility to 300% of the Supplemental Security Income (SSI) level, moving 1,500 people from nursing homes to home- and community-based services, moving 1,100 people off of the waiting list for services, and a statewide nursing home moratorium. The total budgeted state dollar increase amounts to 5.8%.

Objectives for the Division of Disabilities and Rehabilitative Services (DDRS) include closure of Ft. Wayne Developmental Center by July 1, 2007; movement of 2,250 people off of the waiting list for services; implementation of an integrated care management system; and a crisis management program for patients transitioning into the community. The total budgeted state dollar increase amounts to 5.5%.

Objectives for the Division of Family Resources (DFR) include fully funding eligibility changes, providing funding to transition staff to new programs, meeting all maintenance of effort requirements, removing 3,000 people off of the child voucher waiting list, and complying with federal changes in the Temporary Assistance for Needy Families (TANF) program. The FY 2007 budget provides for a total state dollar increase of 2.6%. Mr. Roob added that there are substantial changes in TANF rules as a result of the federal Deficit Reduction Act, and the state will need to increase the rate of working recipients from 30% to 50% or risk losing federal reimbursement dollars.

Objectives for the Division of Mental Health and Addiction (DMHA) include implementation of a mental health and addiction transformation project, localization of Richmond State Hospital, and two new Isaac Ray units at Logansport State Hospital. The FY 2007 budget provides for a total state dollar increase of 3.7% and an increase in budgeted Medicaid Rehabilitation Option expenditures of 20.2%.

Mr. Roob stated that the direction for FSSA for FY 2008 and FY 2009 will include focusing on community care, establishing a sustainable health care model, continuing to contain the Medicaid growth rate, continuing to provide care to Hoosiers who are most in need, integrating systems of care across the agency and state government, and participating in discussions of increased funding to the uninsured population.

EDS Update - Amanda Mizell, FSSA

Amanda Mizell, FSSA, provided the updated Indiana Health Coverage Program (IHCP) statistics (See Exhibit 4) prepared by EDS, the state's claims payment contractor. Exhibit 4 contains data on dollars paid, claims paid, and the number of enrolled providers and recipients for state fiscal years 2004, 2005, and 2006. The exhibit also provides information on IHCP spending between

April and June of 2006 broken down by payment category. The document also provides a list of IHCP highlights for the last year. Highlights include implementation of Medicare Part D, automation of spend-down, transition of First Steps to the Medicaid claims payment system, and others.

Rep. Tim Brown raised concerns regarding access to specialty providers and would like additional information and breakdowns of the data with respect to specialty care providers by geographic area and a comparison of active and inactive enrollment numbers.

Commission members also raised questions about the changes in spend-down rules and procedures. Members inquired as to the federal requirements involved, how other states handle spend-down requirements, and stated that the spend-down provisions are very confusing for both clients and providers. Additional information was requested.

Medicaid Reimbursement

The Office of Medicaid Policy and Planning at the request of the Chairman distributed to Commission members a document (Exhibit 5) providing a historical review of Medicaid reimbursement rate adjustments by provider category. The document provides the date of the last rate increase and subsequent rate decreases for the following providers: hospitals, nursing homes, ICF/MRs, home health agencies, hospices, physicians and other practitioners, pharmacies, durable medical equipment providers, medical supply dealers, transportation providers, dentists, FQHCs and RHCs, laboratories, and waiver providers.

The Indiana State Medical Association also distributed a document (Exhibit 6) regarding Medicaid provider reimbursement. The handout contains a table showing Medicaid reimbursement rates by state for some of the most common billing codes, compiled by the American Academy of Pediatrics, as well as written testimony from two doctors who handle Medicaid patients.

Discussion by Commission Members

Rep. Tim Brown asked Commission members how they would like to proceed and what issues were important to them.

Sen. Dillon raised a concern about client access due to a lack of providers and whether the problem was more related to low reimbursement rates to providers or to a perceived hassle factor with the Medicaid program requirements. Sen. Dillon also stated that it is important to know where the provider shortages are and in what specialty areas. Other Commission members echoed the concern that there was a huge access issue and questioned whether it was more due to reimbursement rates or hassle issues.

Rep. Tim Brown stated that he would like for the three Medicaid managed care organizations to be present at the next meeting to respond to some of these questions.

Rep. Dodge expressed concerns about the reimbursement rates for ambulance-based hospital services and the disparity between private pay rates and Medicaid reimbursement rates.

Rep. Tim Brown stated that members can provide to him possible issues and potential legislation for the Commission to consider.

Next Meeting Date

The next meeting dates for the Commission were tentatively set for Tuesday, September 26, and Tuesday, October 17. Meeting times and locations will be distributed at a future time.

There being no further business to conduct, the meeting was adjourned at about 3:35 p.m.